STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 90715-001**
v
Blue Cross Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 13th day of August 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On July 1, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901, *et seq.* The Commissioner reviewed the request and accepted it on July 9, 2008.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on July 18, 2008.

The Petitioner's group health care coverage is defined by the BCBSM *Community Blue Group Benefits Certificate* (the certificate). The issue in this external review can be decided by an analysis of this contract. The Commissioner reviews contractual issues pursuant to section 11(7) of the PRIRA, MCL 550.1911(7). This matter does not require a medical review by an independent review organization.

II
FACTUAL BACKGROUND

On January 20, 2008, the Petitioner suffered an accidental fall that resulted in a cut to her chin and jaw pain. She went to a XXXXX urgent care facility where she received stitches to her chin and an x-ray of her jaw. The x-ray revealed that she had fractured her jaw and she was directed to the emergency room of XXXXX hospital. At the hospital she was examined by XXXXXDDS, the oral surgeon on call that day. Dr. XXXXX performed jaw surgery on January 21, 2008.

Dr. XXXXX is not a PPO panel provider and does not participate with BCBSM. BCBSM paid $1,038.55 of the $3,380.00 charged by Dr. XXXXX. This left the Petitioner responsible for a balance of $2,341.45.

The Petitioner appealed the amount BCBSM paid. BCBSM held a managerial-level conference on June 11, 2008, and issued a final adverse determination dated June 13, 2008. The Petitioner exhausted BCBSM's internal grievance process and seeks review by the Commissioner under PRIRA.

III
ISSUE

Is BCBSM required to pay more for the Petitioner's January 21, 2008, surgery?

IV
ANALYSIS

Petitioner's Argument

The Petitioner says that she went to a participating medical center to receive stitches for the laceration of her chin. After it was determined that she had a fractured jaw, she was evaluated by Dr. XXXXX, who recommended surgery.

The Petitioner says she assumed that since she went to a participating facility that all the doctors treating her would also be participating. It was not until the next day, when she arrived to

have the surgery, that she was told that Dr. XXXXX did not participate with BCBSM. Because of the pain and discomfort, the Petitioner needed surgery as soon as possible and decided to go ahead with it. The Petitioner notes that the "Benefits-at-a-Glance" summary indicated that BCBSM pays 80% of out-of-network surgical procedures after the deductible and she hoped that BCBSM would pay most of the surgeon's charges.

BCBSM only covered about one-third of the amount charged by the surgeon. The Petitioner believes that BCBSM is required to pay significantly more for this care since it was the result of an accident and there was no other surgeon available.

BCBSM's Argument

The Petitioner's coverage provides that BCBSM will pay its approved amount for the Petitioner's January 21, 2008, surgery. However, since Dr. XXXXX does not participate with BCBSM, he is not obligated to accept BCBSM's approved amount as payment in full and may bill the Petitioner for the difference between his charge and BCBSM's payment.

BCBSM says it is not obligated to pay more than the approved amount even in emergency situations, or when the patient has no choice of providers, or even if the Petitioner was referred by a participating provider.

BCBSM said it did not find any indication that the Petitioner's surgery was more complex than usual for her condition that would warrant additional payment; there is no assertion by the Petitioner that her surgery was other than as described in the procedure codes billed by Dr. XXXXX.

BCBSM believes that it correctly paid its approved amount for the surgical services received by the Petitioner.

Commissioner's Review

The certificate describes how benefits are paid. On page 4.2, the certificate says that BCBSM pays its "approved amount" for physician and other professional services. The approved amount is defined on page 7.2 as "the lower of the billed charge or [BCBSM's] maximum payment

level for the covered service." The following table sets forth the amounts charged by Dr. XXXXX, BCBSM's maximum payment for the procedure, and the amounts actually paid by BCBSM:

Procedure Code	Amount Charged	BCBSM's Maximum Payment	Approved Amount Paid by BCBSM	Balance Due
21453	$2,938.00	$921.27	$921.27	$2,016.73
00170	$284.00	$0.00	$0.00*	$284.00
99203	$158.00	$117.28	$117.28	$40.72
Total	$3,380.00		$1,038.55	$2,341.45

The approved amount is paid to both participating and nonparticipating providers. However, BCBSM's participating providers agree to accept the approved amount as payment in full for their services. Nonparticipating providers have no agreement with BCBSM to accept the approved amount as payment in full. In Section 4 of the certificate, "How Physician and Other Professional Provider Services Are Paid," the Petitioner is cautioned about this (page 4.29):

> If the nonpanel provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial. . . .
>
> **NOTE:** Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

The certificate also indicates that if the surgeon provides the anesthesia, payment for this service is included in the payment for the surgery. In the Petitioner's case Dr. XXXXX provided the anesthesia so the $284.00 charged for this service is not a covered benefit.

It is unfortunate that the Petitioner did not use a participating surgeon. It is understandable that she wanted to proceed with surgery as quickly as possible, even after she learned that Dr. XXXXX did not participate with BCBSM. Nevertheless, the certificate does not require BCBSM to pay more than its approved amount for services of a nonparticipating provider in such a situation,

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* BCBSM did not make separate payment for procedure 00170 (anesthesia) because payment for the surgery (21453) includes the anesthesia. Page 4.5 of the certificate indicates that if the operating physician provides the anesthesia, the service in included in the payment for the surgery.

even if there was no choice of providers or even if the Petitioner was referred to the nonparticipating provider by a participating provider.

The Commissioner finds that BCBSM has paid the claim correctly according to the terms and conditions of the certificate and is not required to pay more for the services provided to the Petitioner.

V
ORDER

BCBSM's final adverse determination of June 13, 2008, is upheld. BCBSM is not required to pay more for the Petitioner's January 21, 2008, surgery and related office visit.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.